Mr. DOMENICI, Mr. KERRY, Mr. BOND, Mr. VOINOVICH, Mr. LAUTENBERG, Mr. COCHRAN, Mrs. MURRAY, Mr. SMITH OF OREGON, Mr. BINGAMAN, Mr. L. CHAFEE, Mr. DURBIN, Mr. MURKOWSKI, Mr. ROBERTS, Mr . ROBB, Mr. ROCKEFELLER, Mr. WELLSTONE, Mrs. FEINSTEIN, Ms. MIKULSKI, Ms. SNOWE, Mrs. BOXER, Mr. KERREY, and Mr. WARNER):

S. 2866. A bill to provide for early learning programs, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. DEWINE:

S. 2867. A bill to provide for the funding and administration of a Veterans Mission for Youth Initiative within the Troops-to-Teachers Program; to the Committee on Health, Education, Labor, and Pensions.

By Mr. FRIST (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. DODD, Mr. DEWINE, Mr. REED, Mrs. MURRAY, Mr. BOND, Mr. HATCH, Mr. GORTON, Mr. ABRAHAM, and Mr. DURBIN):

S. 2868. A bill to amend the Public Health Service Act with respect to children's health; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HATCH (for himself, Mr. KENNEDY, Mr. HUTCHINSON, Mr. DASCHLE, Mr. BENNETT, Mr. LIEBERMAN, and Mr. SCHUMER):

S. 2869. A bill to protect religious liberty, and for other purposes; read the first time.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. HELMS (for himself, Mr. LOTT, Mr. BIDEN, Mr. L. CHAFEE, Mr. DODD, Mr. LUGAR, Mr. COVERDELL, Mr. DOMENICI, Mr. LEAHY, Mr. GRASSLEY, Mr. BINGAMAN, Mr. GRAMM, Mr. MCCAIN, Mr. SMITH OF NEW HAMPSHIRE, Mr. CRAIG, Mrs. FEINSTEIN, Mrs. BOXER, Mr. FEINGOLD, Mrs. HUTCHISON, Mr. ASHCROFT, Mr. FRIST, Mr. GRAMS, Mr. DEWINE, Mr. KYL, and Mr. BROWNBACK):

S. Res. 335. A resolution congratulating the people of Mexico on the occasion of the democratic elections held in that country; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ENZI:

S. 2860. A bill for the relief of Sammie Martine Orr; to the Committee on the Judiciary.

THE RELIEF OF SAMMIE MARTINE ORR

Mr. ENZI. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2860

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CLASSIFICATION AS A CHILD UNDER THE IMMIGRATION AND NATIONALITY ACT.

(a) IN GENERAL.—In the administration of the Immigration and Nationality Act, Sammie Martine Orr shall be classified as a child within the meaning of section 101(b)(1)(F) of such Act, upon approval of a petition filed on his behalf by the alien's adopting parents, citizens of the United States, pursuant to section 204 of such Act.

(b) LIMITATION.—No natural parent, brother, or sister, if any, of Sammie Martine Orr shall, by virtue of such relationship, be accorded any right, privilege, or status under the Immigration and Nationality Act.

By Mr. ROBB (for himself and Mr. WARNER):

S. 2865. A bill to designate certain land of the National Forest System located in the State of Virginia as wilderness; to the Committee on Energy and Natural Resources.

VIRGINIA WILDERNESS ACT OF 2000

Mr. ROBB. Mr. President, I come to the floor today to introduce a bill that will protect one of the most beautiful areas of Virginia. Today, with my colleague JOHN WARNER, I am introducing the Virginia Wilderness Act of 2000. This Act will provide wilderness status to two exceptional areas of Virginia. These areas, the ''Three Ridges'' and ''The Priest'' have long been recognized for their outstanding vistas, deep valleys and rugged beauty.

After receiving wilderness designation these areas will remain available for hunting, fishing, hiking, picnicking, and other traditional uses. Wilderness protections will ensure that ''The Three Ridges'' and ''The Priest'' remain available for the full enjoyment of our children, grandchildren and great-grandchildren.

This action is now fully supported by the Virginia delegation, and the communities closest to the proposed wilderness areas. I hope we will see quick action on this bill through the committee and that we can move it to floor and complete action on the bill this year.

I ask unanimous consent that this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2865

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Virginia Wilderness Act of 2000''.

SEC. 2. DESIGNATION OF WILDERNESS AREAS.

Section 1 of the Act entitled ''An Act to designate certain National Forest System lands in the States of Virginia and West Virginia as wilderness areas'' (Public Law 100–326; 102 Stat. 584) is amended—

(1) in paragraph (5), by striking ''and'' at the end;

(2) in paragraph (6), by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(7) certain land in the George Washington National Forest, comprising approximately 6,500 acres, as generally depicted on a map entitled 'The Priest Wilderness Study Area', dated June 6, 2000, to be known as the 'Priest Wilderness Area'; and

''(8) certain land in the George Washington National Forest, comprising approximately 4,800 acres, as generally depicted on a map entitled 'The Three Ridges Wilderness Study Area', dated June 6, 2000, to be known as the 'Three Ridges Wilderness Area.''.

Mr. WARNER. Mr. President, I rise today in support of legislation to add two areas in my State to the National Wilderness Preservation System. These areas, known as The Priest and the Three Ridges, are located in the George Washington National Forest and comprise approximately 10,500 acres.

The Commonwealth of Virginia is blessed with rich geographic diversity. From the Chesapeake Bay in the East to the Appalachian Mountains in the West, residents of the state and visitors alike are able to participate in a broad range of activities not often found in other areas of the country.

The Priest and the Three Ridges, in particular, offer unique opportunities for visitors to enjoy scenic views, interaction with wildlife, hiking, fishing, and other types of outdoor recreation. These areas need to be protected from development, and this legislation would ensure that they remain pristine for the use and enjoyment of present and future generations.

Mr. President, I look forward to the designation of The Priest and Three Ridges as wilderness through the swift passage of this bill.

By Mr. STEVENS (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. DODD, Mr. DOMENICI, Mr. KERRY, Mr. BOND, Mr. VOINOVICH, Mr. LAUTENBERG, Mr. COCHRAN, Mrs. MURRAY, Mr. SMITH of Oregon, Mr. BINGAMAN, Mr. L. CHAFEE, Mr. DURBIN, Mr. MURKOWSKI, Mr. ROBERTS, Mr. ROBB, Mr. ROCKEFELLER, Mr. WELLSTONE, Mrs. FEINSTEIN, Ms. MIKULSKI, Ms. SNOWE, Mrs. BOXER, Mr. KERREY, and Mr. WARNER):

S. 2866. A bill to provide for early learning programs, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

EARLY LEARNING OPPORTUNITIES ACT

Mr. JEFFORDS. Mr. President, I am pleased to join my colleagues from both sides of the aisle in the introduction of the ''Early Learning Opportunities Act of 2000''. We first brought this legislation to the floor of the Senate as an amendment to the reauthorization of the Elementary and Secondary Education Act. In fact, it is the pending amendment when we return to consideration of S.2.

Simply stated, this bill is designed to help parents and others who care for young children acquire the resources and tools that they need to do their most important job—-nurturing and teaching our children. There is broad, bi-partisan support for this legislation because many of my colleagues recognize the importance of learning in the first few years of life.

Science has taught us that the most explosive time of learning for humans is during the first few years of life. Parents and others who provide care for our children need some help and support to make the most of these early years. Changes in family structures, the weakening of the role of the

extended family, and the rise in the number of working mothers have increased the need for communities to provide additional support for parents.

The Early Learning Opportunities Act builds on existing state and federal efforts by expanding the range of programs, the types of activities, and the populations served by other early learning initiatives. Current federal efforts focused on early childhood learning promote programs that provide full- or part-day out of home care and education. Rather than duplicate these programs, the Early Learning Opportunities Act places its emphasis on helping parents and other caretakers increase their abilities to support positive child development.

The Early Learning Opportunities Act will provide funding for parent support programs. Parents are their child's most important teachers. Before anyone thinks about kindergarten, teaching the alphabet, or counting the number of blocks in a tower, children are learning from their parents. When a parent talks and sings to an infant, the baby is learning about sounds and words as a method of communication. When children are fed and then rocked to sleep, they learn about security and love, which will contribute to their sense of self and autonomy. Long before they walk through the schoolhouse door, children have learned important lessons from their parents and others who have taken care of them during the first few years of life.

Funding for the Early Learning Opportunities Act can be used to promote effective parenting and family literacy through a variety of community-based programs, services and activities. If parents are actively engaged in their child's early learning, their children will see greater cognitive and non-cognitive benefits. While all parents want their children to grow up happy and healthy, few are fully prepared for the demands of parenthood. Many parents have difficulty finding the information and support they seek to help their children grow to their full potential. Making that information and support available and accessible to parents is a key component of the Early Learning Opportunities Act.

Early Learning Opportunities Act funds can be used to provide training for child care providers on early childhood development, child safety, and other skills that improve the quality of child care. For many families it is not possible for a parent to remain home to care for their children. Their employment is not a choice, but an essential part of their family's economic survival. And for most of these families, child care is not an option, but a requirement, as parents struggle to meet the competing demands of work and family. Just as it is essential that we provide parents with the tools they need to help their children grow and develop, we also must help the people who care for our nation's children while parents are at work.

States can use a portion of the funds made available for the Early Learning Opportunities Act for statewide initiatives, such as wage and benefit subsidies which encourage child care staff recruitment and incentives to increase staff retention Today, more than 13 million young children—including half of all infants—spend at least part of their day being cared for by someone other than their parents. In Vermont alone, there are about 22,000 children, under the age of six, in state-regulated child care.

The Early Learning Opportunities Act will improve local collaboration and coordination among child care providers, parents, libraries, community centers, schools, and other community service providers. By assessing existing resources and identifying local needs, the community organizations receiving funds will serve as a catalyst for the more effective use of early learning dollars and the removal of barriers that prevent more children, parents and caretakers from participating in good programs. Parents and child care providers will be able to access more services, activities and programs that help them care for children.

An investment in early learning today will save money tomorrow. Many of America's children enter school without the necessary abilities and maturity. Without successful remediation efforts, these children continue to lag behind for their entire academic career. We spend billions of dollars on efforts to help these children catch up. Research has demonstrated that for each dollar invested in quality early learning programs, the federal government can save over five dollars. These savings result from future reductions in the number of children and families who participate in federal government programs like Title I, special education, and welfare.

The Early Learning Opportunities Act is designed to be locally controlled and driven by the unique needs of each community. The legislation authorizes $3.25 billion in discretionary funding over three years for early learning block grants to states. The bill ensures that the majority of the funds will channeled through the states to local councils. The councils are charged with assessing the early learning needs of the community, and distributing the funds to a broad variety of local resources to meet those needs. In Vermont, the Success by Six initiative has demonstrated the importance of placing the resources and responsibilities at the local community level.

The Early Learning Opportunities Act will serve as a catalyst to engage diverse sectors of the community in increasing programs, services, and activities that promote the healthy development of our youngest citizens. Funds may be used by the local councils in a variety of ways: to support reading readiness programs in libraries, parenting classes at the local health center, parent-child recreation programs in the park, and child development classes at the school. Access to existing early learning programs can be increased by expanding the days or times that young children are served, by increasing the number of children served, or by improving the affordability of programs for low-income children. Transportation can be provided to increase participation in early learning programs, activities and services. By keeping the use of the funds flexible, local councils can work with parents, health care professionals, educators, child care providers, recreation specialists, and other groups and individuals in the community to create an affordable, accessible network of early learning activities.

The Early Learning Opportunities Act will help parents and care givers who are looking for better ways to integrate positive learning experiences into the daily lives of our youngest children. When children enter school ready to learn, all of the advantages of their school experiences are opened to them—their opportunities are unlimited. I urge my colleagues to support and co-sponsor the ''Early Learning Opportunities Act of 2000''. I urge you to give our nation's children every opportunity to succeed in school and in life.

Mr. KENNEDY. Mr. President, our bipartisan goal in introducing The Early Learning Opportunities Act is to provide greater support for parents across the country in preparing their children for a lifetime of learning, beginning at the earliest age.

I commend Senators STEVENS, JEFFORDS, DODD, DOMENICI, and KERRY for their support and leadership in developing this legislation and in seeing to it that children's voices are heard and their needs are a priority in this Congress. Senator KERRY and I have worked together to improve early learning opportunities in Massachusetts, and this national initiative is based in part on successful models in our state. Senator DODD has been an outstanding leader on children's issues for many years. Senator JEFFORDS, the chairman of our Senate committee, has shown great skill and determination in shaping this legislation, and in keeping our committee focused on the important issue of early learning. Senator DOMENICI has been an essential ally throughout the development of this bill, as has the senior Senator from Alaska. Senator STEVENS and I introduced the Early Learning Trust Fund Act as a predecessor to this legislation, and he was a leader in obtaining approval of $8.5 billion for early learning in this year's Senate budget resolution.

Clearly, the need for this legislation is urgent. Today's families are legitimately worried about the quality of care provided to their infants and toddlers while the parents are at work. Of mothers with children aged zero to five, a record 64 percent worked outside the home in 1999. The average cost of care for each of these children is four

to ten thousand dollars a year. This is their highest expense besides food and shelter, consuming a quarter to half of their wages. Too often, even this level of sacrifice isn't enough. Many families simply cannot find quality care for their children. Facilities are dangerous, crowded, or closed at the non-traditional times that many mothers work. Low wages attract the least skilled care givers, over a third of whom quit each year. Enforcement of quality standards is rare. Elementary and Secondary education fully deserve to be a priority for the nation, but so does early learning—and it is needed at a time when many young families are least able to bear the full cost.

In Massachusetts, the Community Partnerships for Children Program currently provides quality full-day early learning for 15,300 young children from low-income families. Yet today, over 14,000 additional eligible children in the state are waiting for the early learning services they need—and some have been on the waiting list for 18 months. A 1999 report by the Congressional General Accounting Office on early learning services for low-income families was unequivocal—''infant toddler care [is] still difficult to obtain.''

Even as the need to provide early learning opportunities increases, it is clear that many current facilities are unsafe. The average early learning provider is paid under seven dollars an hour—less than the average parking lot attendant or pet sitter. These low wages result in high turnover, poor quality of care, and little trust and bonding with the children.

The Nation's military faced these same problems in the 1980's, and because of the threat that the poor quality of care posed to children, to morale, and to retention of personnel, the armed forces worked long and well to create a model program. The Defense Department now provides quality care to 200,000 children. Many European nations have followed the same path as the U.S. military, building a broad array of quality early learning models that prepare children to reach their full potential.

Head Start is one example of the kind of quality program that has already proved effective throughout the United States. A recent survey found that more parents are satisfied with Head Start than any other federal program. But only two in five eligible 3- and 4-year-olds are enrolled in Head Start—and only one in 100 eligible infants and toddlers are enrolled in Early Head Start. As a result, literally millions of young children never have the chance to reach their full potential. We must do better, and we can do better.

It is time to act to make early learning a top education priority for the nation, just as governors urged us to do a full decade ago. All preschool children should have access to the kind of care and brain stimulation necessary to enable them to enter school ready to learn. We cannot rest until all children have the opportunity to develop to their full potential.

Academic studies have confirmed what parents have long understood—education occurs over a continuum that begins at birth and extends throughout life. Study after study proves that positive brain stimulation very early in life significantly improves a child's later ability to learn, to interact successfully with teachers and peers, and to develop crucial skills like curiosity, trust, and perseverance. Two years ago, the Rand Corporation reported that ''after critically reviewing the literature and discounting claims that are not rigorously demonstrated, we conclude that these [early learning] programs can provide significant benefits.'' Governors, state legislatures, local governments, and educators have all supported these studies and called for increased investments in early learning as the most effective way to promote healthy and constructive behavior.

The goal of this legislation is to enable all children to enter school ready to learn, and to maximize the impact of federal, state, and local investments in education. We must do more to ensure that children have access to the experiences they need during the five or six years before they walk through their first schoolhouse door. Education begins at birth. It is not a process that occurs only in a school building during a school day. When our policies respond to this reality, we will reduce delinquency, improve productivity, and become a stronger and better nation. Early learning programs are good for children, good for parents and good for society as a whole.

The Committee for Economic Development reports that the nation can save over five dollars in the future for every dollar invested in early learning today. The investment significantly reduces the number of families on welfare, the number of children in special education, and the number of children in the juvenile justice system. Investment in early learning is not only morally right—it is economically right.

Two months ago, Fight Crime: Invest in Kids, a bipartisan coalition including hundreds of police chiefs, sheriffs, and crime victims, released another convincing report. It finds that children who receive quality early learning are half as likely to commit crimes and be arrested later in life. Our greatest opportunity to reach at-risk children is in their youngest years.

It is especially important for low-income parents who accept the responsibility of work under welfare reform to have access to quality early learning opportunities for their children. The central idea of welfare reform is that families caught in a cycle of dependence can be shown that work pays. But children's development must not be sacrificed as families move from welfare to work.

We must expand access to Head Start and Early Head Start. We must make parenting assistance available to all who want it. We must support model state efforts that have already proved successful, such as Community Partnerships for Children in Massachusetts and Smart Start in North Carolina, which rely on local councils to identify early learning needs in each community and allocate new resources to meet them. We must give higher priority to early childhood literacy. In ways such as these, we can take bolder action to strengthen early learning opportunities in communities across the nation.

The legislation that we introduce today will move us closer to all of these goals. It includes $3.25 billion over the next three years to enable local communities to fill the gaps that limit current early learning efforts. Local councils will direct the funds to the most urgent needs in each community. These needs include parenting support and education—improving child care quality through professional development and retention initiatives—expanding the times and the days that parents can obtain these services—enhancing childhood literacy—and greater early learning opportunities for children with special needs. These priorities are designed to strengthen early learning programs in all communities across the country, and give each community the opportunity to invest the funds in ways that will meet its most urgent needs.

Much more needs to be done to improve early learning throughout America. But we know from our experience in improving the military's early learning program that with small steps, over time we can go a long way. I urge the Senate to approve this important bill, and I look forward to its enactment and to the significant differences it will make.

By Mr. DEWINE:

S. 2867. A bill to provide for the funding and administration of a Veterans Mission for Youth Initiative within the Troops-to-Teachers Program; to the Committee on Health, Education, Labor, and Pensions.

VETERANS MISSION FOR YOUTH INITIATIVE

Mr. DEWINE. Mr. President, I am pleased to introduce a bill today—the ''Veterans Mission for Youth Initiative''—that would expand the current mission of the successful Troops to Teachers program. As many of my colleagues know, Troops to Teachers is a practical and sensible teacher recruitment program—a program that helps our veterans and retired military personnel gain the necessary certification to teach in our children's classrooms.

The bill I am introducing today would build on the current program's success by expanding its mission to help veterans who want to volunteer in our schools and be role models, but do not necessarily want to become certified teachers. This bill not only will help children benefit from the knowledge and experiences of veterans, but it also will help our veterans get more involved and active in their own local

communities. I am pleased that Governor George W. Bush is proposing this same idea today in Pittsburgh.

Specifically, the ''Veterans Mission for Youth Initiative,'' would authorize $75 million to be used for matching federal grants to community organizations that help train and then link veterans and retired military personnel with local school volunteer opportunities to mentor and tutor students. The grant program will be administered through the Defense Department's Defense Activity for Non-Traditional Education Support division, which runs the Troops-to-Teachers program.

Mr. President, the sad reality is that our schools are in crisis—especially in the inner cities and in places like Appalachia. And, I am frustrated and saddened that far too many children simply are not getting the quality education they deserve. The current Troops to Teachers program is helping to improve educational quality in America by providing mature, motivated, experienced, and dedicated personnel for our nation's classrooms. In fact, when administrators were asked to rate Troops to Teachers participants in their schools, 54 percent of the administrators said that the former military personnel turned teachers were among the best teachers at the schools. I am pleased to say that since 1994, 3,720 retired members of the U.S. military have been hired as teachers in all 50 states.

Additionally, a 1999 alternative teacher certification study found that participants in the Troops to Teachers program broaden the make-up and skills of our current teacher pool. For example, 30 percent of participants are minorities, compared to 10 percent of all teachers; 30 percent of participants are teaching math, compared to 13 percent of all teachers; 39 percent are willing to teach in inner cities compared to the current 16 percent urban teaching force; and 90 percent are male, compared to the overall current teaching force which is 26 percent male.

By expanding the current mission of the Troops to Teachers program by helping to link veterans with community volunteer opportunities to tutor and mentor school children, we can strengthen our education system overall. By linking students and America's retired military personnel—men and women who have exhibited the ideals of discipline, order, courage, and civic responsibility—we can teach our children valuable lessons outside the classroom.

Sadly, Mr. President, a recent survey of American youth, called the ''New Millennium Project,'' found that students chose as their three lowest-ranking priorities in life: 1. Being a good citizen who cares about the good of the country; 2. Being involved in democracy and voting; and 3. Being involved in helping make one's community a better place. Furthermore, a recent survey by the Horatio Alger Society found that 21 percent of students had no heroes.

We need to change this, Mr. President. We need to change these apathetic and aimless attitudes. We need to give American youth some direction—the right direction. After all, these children are our future—we need to equip them with an arsenal of lessons—lessons they can learn in the classroom and out of the classroom by interacting with our country's heroes—our veterans.

The bottom line is this: As a nation, we need to do all we can to get the best teachers available into our public schools. We are trying to do just that through the current Troops to Teachers program. Now, the ''Veteran's Mission for Youth Initiative'' is another step in that direction. I urge my colleagues to support this effort and to join me in taking an important step toward improving education in this country. We owe it to our children; we it to our veterans; and we owe it to our nation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2867

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Veterans Mission for Youth Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Since 1994, 17,148 retired members of the United States Armed Forces have applied to participate in the Troops-to-Teachers program and 3,720 such members have been hired as teachers in 50 States.

(2) The mission of the Troops-to-Teachers program is to help improve American Education by providing mature, motivated, experienced, and dedicated personnel for the nation's classrooms.

(3) The Troops-to-Teachers program provides positive role models for the nation's public school students.

(4) Ninety percent of Troops-to-Teachers participants are male, compared to 26 percent of the existing teaching force.

(5) Nearly 30 percent of Troops-to-Teachers participants are minorities compared to 10 percent in the existing teaching force.

(6) The Troops-to-Teachers program helps relieve teacher shortages, especially in the subjects of math and science.

(7) School administrators who work with Troops-to-Teachers participants were asked to rate such participants in their schools, 54 percent of such administrators said that the former military personnel turned teachers were well above average or were among the best teachers at the schools.

(8) The 1999 Alternative Teacher Certification study by C, Emily Feistritzer found that 30 percent of Troops-to-Teachers participants are minorities compared to 10 percent of all teachers, 30 percent are teaching math compared to 13 percent of all teachers, 25 percent teach in urban schools, and 90 percent are male compared to the current teaching force which is 74 percent female.

(9) America's 25,000,000 veterans have exhibited the ideals of discipline, order, courage, and civic responsibility that are important lessons for America's children.

(10) The recent survey of American youth, the ''New Millennium Project'' found that students chose as their 3 lowest-ranking priorities in life—being a good citizen who cares about the good of the country, being involved in democracy and voting, and being involved in helping make one's community a better place.

(11) A recent survey by the Horatio Alger Society found that 21 percent of students had no heroes.

SEC. 3. ESTABLISHMENT OF A VETERANS MISSION FOR YOUTH INITIATIVE.

Title XVII of the National Defense Authorization Act of Fiscal Year 2000 (commonly known as the Troops-to-Teachers Program Act of 1999 (20 U.S.C. 9301 et seq.)) is amended by adding at the end the following:

''SEC. 1710. VETERANS MISSION FOR YOUTH INITIATIVE.

''(a) ESTABLISHMENT.—The Secretary of Defense, acting through the Defense Activity for Non-Traditional Education Support Division of the Department of Defense, shall establish an initiative to be known as the 'Veterans Mission for Youth Initiative' to award grants to eligible organizations to provide mentoring, tutoring, after-school and other programs for youth.

''(b) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a grant under subsection (a), an organization shall—

''(A) be a community organization that provides, or intends to provide, services to link individuals described in paragraph (2) with youth;

''(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(C) provides assurances to the Secretary that the organization with provide matching funds as required under paragraph (3); and

''(D) meet such other requirements as the Secretary may prescribe.

''(2) INDIVIDUALS ELIGIBLE TO PROVIDE SERVICES.—An individual described in this paragraph is any member of the Armed Forces—

''(A) who was—

''(i) discharged or released from active duty after 6 or more years of continuous active duty immediately before the discharge or release; or

''(ii) involuntarily discharged or released from active duty for purposes of a reduction of force after 6 or more years of continuous active duty immediately before the discharge or release; and

''(B) who's last period of service in the Armed Forces was characterized as honorable; and

''(C) who satisfies such other criteria for selection as the Secretary may prescribe.

''(3) MATCHING REQUIREMENT.—To be eligible to receive a grant under this section an eligible organization shall agree to make available (directly or through donations from public or private entities) non-Federal contributions toward the cost of carrying out the program established under the grant in an amount equal to the amount provided under the grant.

''(c) USE OF FUNDS.—An organization shall use amounts provided under a grant under this section to carry out a program to facilitate linkages between individuals described in subsection (b)(2) and youth through the provision by such individuals of mentoring, tutoring, after-school and other services.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $75,000,000 for fiscal year 2001, and such sums as may be necessary for each subsequent fiscal year.''.

By Mr. FRIST (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. DODD, Mr. DEWINE, Mr. REED,

Mrs. MURRAY, Mr. BOND, Mr. HATCH, Mr. GORTON, Mr. ABRAHAM, and Mr. DURBIN):

S. 2868. A bill to amend the Public Health Service Act with respect to children's health; to the Committee on Health, Education, Labor, and Pensions.

CHILDREN'S PUBLIC HEALTH ACT OF 2000

Mr. FRIST. Mr. President, I am pleased to be joined by Senators JEFFORDS, KENNEDY, DODD, DEWINE, REED, MURRAY, BOND, HATCH, GORTON, ABRAHAM, and DURBIN to introduce the Children's Public Health Act of 2000.

This bill is the result of months of close collaboration begun last fall between members of the Health, Education, Labor and Pensions Committee, and in discussion with Congressmen BLILEY and BILIRAKIS to begin an effort to address children's health issues this Congress.

I am pleased that the House has already passed a companion bill to the one which we introduce today, and I look forward to working with the House to ensure that we enact this needed bill by the end of the year.

The Children's Public Health Act of 2000 has four overriding themes represented in its four titles: Injury Prevention, Maternal and Infant Health, Pediatric Health Promotion, and Pediatric Research. I view these four themes as critical to ensuring that we are able to promote the health of our Nation's children.

In the first title we address the critical problem of unintentional injuries. According to the CDC, unintentional injuries are the leading cause of death for every age group between 1 and 19 years of age. Unintentional injuries comprise 26 deaths per 100,000 children aged 1–14 and 62 deaths per 100,000 children aged 15–19. In addition, more than 1,500,000 children in the United States sustain a brain injury each year. To help address this problem, the bill would reauthorize and strengthen the Traumatic Brain Injury programs at the Centers for Disease Control (CDC) and Prevention, the National Institutes of Health (NIH) and the Health Resources and Services Administration (HRSA).

The bill also includes a provision which I originally introduced with Senator DODD in March of this year, to address the issue of child care health and safety. In my own state of Tennessee, there have been 4 deaths in the past 3 years in child care settings, and 1 in 15 child-care programs in the Nashville area were found by state inspectors to have potentially put the health and safety of children at risk during 1999. In addition, in 1997, 31,000 children aged 4 and younger were treated in hospital emergency rooms for injuries sustained in child care or school settings across this nation. Therefore, the bill contains child care safety and health grants to assist states to fund specific activities to increase safety and health in child care settings.

To address the tragic fact that birth defects are the leading cause of infant mortality and are responsible for about 30 percent of all pediatric hospital admissions, the second title of the bill focuses on maternal and infant health. According to the CDC, an estimated 3,000 birth defects have been identified, of which 70 percent have no known cause. To provide national leadership to combat birth defects, the bill would establish a National Center for Birth Defects and Developmental Disabilities at the CDC, which is strongly supported by the March of Dimes and other birth defects groups, to collect, analyze, and distribute data on birth defects. In addition, the bill authorizes the Healthy Start program for the first time, which is designed to reduce the rate of infant mortality and improve perinatal outcomes by providing grants to areas with a high incidence of infant mortality and low birth weight. This bill also contains folic acid education programs to spread the knowledge of the positive health effects of folic acid in the diet of pregnant women.

To address the fact that over 3,000 women experience serious complications due to pregnancy and that 2 to 3 of these women will die from pregnancy complications, the bill would develop a national monitoring and surveillance program to better understand the burden of material complications and mortality and to decrease the disparities among populations at risk of death and complications from pregnancy.

The third title addresses the promotion of pediatric health by focusing on screening and prevention programs to combat some of the most common childhood diseases and conditions. This bill helps to combat asthma, the most common chronic disease of childhood, affecting nearly 5 million children under the age of 18 in the United States, by providing comprehensive asthma services to children and to coordinate the wide range of asthma prevention programs in the federal government.

We also focus on childhood obesity, which has increased by 100% among children in just the past 15 years, and has resulted in 4.7 million children and adolescents ages 6–19 years becoming seriously overweight. To address this obesity epidemic, the bill provides programs to support the development, implementation, and evaluation of state and community-based programs to promote good nutrition and increased physical activity among American youth.

In examining the problems affecting children across the nation and in Tennessee, I was very concerned to learn that in Memphis, Tennessee, over 12 percent of children under the of age of 6 have screened positive for lead poisoning. At high levels, lead can cause a variety of debilitating health problems, including seizure, coma, and even death. At lower levels, lead can contribute to learning disabilities, loss of intelligence, hyperactivity, and behavioral problems. This bill includes physician education and training programs on current lead screening policies, tracks the percentage of children in the Health Centers program who are screened for lead poisoning, and conducts outreach and education for families at risk of lead poisoning.

This bill also targets pediatric oral health, which was recently highlighted by the May 2000, Surgeon General report which focused on the fact that oral health is inseparable from overall health, and that while there have been great improvements in oral health for a majority of the population, there are disparities that primarily affect poor children and those who live in underserved areas of our country, with 80 percent of all dental cavities found in 20 percent of children. This bill would support community-based research and training to improve the understanding of etiology, pathogenesis, diagnoses, prevention, and treatment of pediatric oral, dental, and craniofacial diseases. In addition, the bill would provide state grants to increase community water fluoridation and to provide school-based dental sealant services to children in low income areas.

The last title of this bill is a focus on strengthening pediatric research efforts in the country. To give us a fuller understanding of how we can help promote the health of our children we establish a Pediatric Research Initiative within the National Institutes of Health to enhance collaborative efforts, provide increased support for pediatric biomedical research, and ensure that opportunities for advancement in scientific investigations and care for children are realized. The bill would also expand research into autism, which affects 1 in 500 children, establish a long term Child Development Study at the NIH to evaluate the effects of both chronic and intermittent exposures on human development.

Mr. President, this bill is comprehensive; it systematically addresses several critical childhood health issues and I am committed to ensure that it will be enacted before the end of this Congress. I would like to thank Senator JEFFORDS, the chairman of the Senate Health, Education, Labor and Pensions Committee and Senator KENNEDY and their staffs for their critical collaboration which has led to the development of a strong bipartisan bill. I would also like to thank Senators DODD, DEWINE, REED, MURRAY, BOND, HATCH, GORTON, ABRAHAM, and DURBIN, for their work on selected provision's in this bill and to their commitment to children's health issues. I would also like to thank Mr. Bill Baird, from the Office of Senate Legislative Counsel, for his great work in drafting this bill. I ask unanimous consent that a full summary of the bill appear in the RECORD following my remarks.

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

THE CHILDREN'S PUBLIC HEALTH ACT OF 2000—SUMMARY

In an effort to address the health and well being of our most precious resource, the Children's Public Health Act of 2000 amends the Public Health Service Act to revise, extend, and establish programs with respect to children's health research, health promotion and disease prevention activities conducted through Federal public health agencies. The Act contains four titles to address critical issues in the areas of children's health; including Injury Prevention, Maternal and Infant Health, Pediatric Public Health Promotion, and Pediatric Research.

TITLE I—INJURY PREVENTION

Subtitle A—Traumatic Brain Injury

Traumatic Brain Injury (TBI) is a term descriptive of injury occurring to the brain as a result of external forces. These injuries may include intracranial (inside the skull) or intraparenchymal (inside the brain tissue) hemorrhage, parenchymal edema, or shear injury. The CDC Center for Injury Prevention estimates that more than 1,500,000 children in the US sustain a brain injury each year, and many more are living with the consequences. According to the CDC National Center for Health Statistics, unintentional injuries including TBI are the leading cause of death for every age group from 1 to 19 years of age, comprising 26 deaths per 100,000 children aged 1–14 and 62 deaths per 100,000 children aged 15–19. Younger children and infants are at an increased risk of brain injury because the size and weight of their heads is greater in proportion to their body size. Young children also lack mature muscle control, which contributes to an increased risk of head injury.

This provision would reauthorize the Traumatic Brain Injury Act of 1996 to extent the authority for CDC to support research into strategies for the prevention of TBI and implementing public information and education programs for the prevention of TBI. NIH research is expanded to cognitive disorders and neurobehavioral consequences arising from TBI. The bill authorizes HRSA to make grants for community support services to develop, change, or enhance service delivery systems. Grants may be used to educate consumers and families, train professionals, improve case management, develop best practices in the areas of family support, return to work, and housing for people with traumatic brain injury.

Subtitle B—Child Care Safety and Health Grants

Of the 21 million children under the age of 6 in the United States, almost 13 million spend some part of their day in child care. There is alarming evidence to suggest that more must be done to improve the health and safety of children in child care settings. For example, a 1998 Consumer Product Safety Commission Study revealed that two-thirds of the 200 licensed child care settings investigated exhibited safety hazards, such as insufficient child safety gates, cribs with soft bedding, and unsafe playgrounds. In 1997 alone, 31,000 children age 4 and younger were treated in hospital emergency rooms for injuries sustained in child care school settings. Even more tragically, since 1990 more than 56 children have died in child care settings.

To address the need for increased safety of child care facilities, this provision would give the Secretary of Health and Human Services the authority to provide grants to states to carry out activities related to the improvement of the health and safety of children in child care settings. Grants may be used for two or more of the following activities: train and educate child care provides to prevent injuries and illnesses and to promote health-related practices; strengthen and enforce child care provider licensing, regulation, and registration; rehabilitate child care facilities to meet health and safety standards; provide health consultants to give health and safety advice to child care providers; enhance child care providers' ability to serve children with disabilities; conduct criminal background checks on child care providers; provide information to parents on choosing a safe and healthy setting for their children; or improve the safety of transportation of children in child care.

TITLE II—MATERNAL AND INFANT HEALTH

Subtitle A—Safe Motherhood and Infant Health Prevention

Every day, 2–3 women die from pregnancy complications and over 3,000 women experience serious complications due to pregnancy. Despite nearly 4 million deliveries in the United States each year, we have little information about unintended health consequences related to pregnancy and childbirth. The nation's infant mortality rate has steadily declined over the last decade, but the percentage of women who die in childbirth has remained unchanged. Maternal mortality rates reveal significant disparities between African American and white women, but the reasons for those differences are not well understood. When compared with white women, black women continue to have four times the risk for dying from complications of pregnancy and childbirth.

The provision would authorize the Secretary of HHS to develop a national monitoring and surveillance program to better understand the burden of maternal complications and mortality and to decrease the disparities among populations at risk of death and complications from pregnancy. The provision would also allow the Secretary to expand the Pregnancy Risk Assessment Monitoring System program to provide surveillance and data collection in each of the 50 States. Furthermore, the provision would expand research concerning risk factors, prevention strategies, and the roles of the family, health care providers, and the community in safe motherhood. The provision also authorizes public education campaigns on healthy pregnancies, education programs for health care providers, and activities to promote community support services for pregnant women. Finally, the provision provides grant funding for research initiatives and prevention programs on drug, alcohol, and smoking prevention and cessation for pregnant women.

Subtitle B—Healthy Start Initiative

The Healthy Start initiative began as a demonstration project in 1991 to help mothers from disadvantaged neighborhoods improve their chances of having a healthy pregnancy and, ultimately, a healthy baby. This provision authorizes the Healthy Start program for the first time. Healthy Start is designed to reduce the rate of infant mortality and improve perinatal outcomes by providing grants to areas with a high rate of infant mortality and low birth weight. Newly authorized services include expanding access to surgical services to the fetus, pregnant woman, and infant during the first year after birth.

Subtitle C—National Center for Birth Defects and Developmental Disabilities

Birth defects are the leading cause of infant mortality and are responsible for about 30% of all pediatric hospital admissions. According to the CDC, of the estimated 3,000 different birth defects that have been identified, up to 70% without a known cause. Of the four million babies born each year in the United States, approximately 150,000 are born with one or more serious birth defects. About 17% of U.S. children under 18 years of age have a developmental disability. In the United States, 12 out of every 1,000 school children have mental retardation, approximately 10,000 infants born each year develop cerebral palsy, and as many as 1 in every 500 children under 15 years of age may have one of the autism spectrum disorders.

This provision would create a National Center for Birth Defects and Developmental Disabilities within the CDC. The purpose of this Center would be to collect, analyze, and distribute data on birth defects including information on causes, incidence, and prevalence; conduct applied epidemiological research on the prevention of such defects; and provide information to the public on proven prevention activities.

Subtitle D—Folic Acid Education Programs

Each year, an estimated 2,500 infants are born in the United States with serious birth defects of the brain and spine, called neural tube defects. The most common neural tube defects are spina bifida, which is due to an incomplete closure of the spinal column, and anencephaly, a fatal condition where an infant is born with a severely underdeveloped brain and skull. Spina bifida is the leading cause of childhood paralysis. As many as 70 percent of all neural tube birth defects could be prevented if all women of childbearing age consumed 400 micrograms of folic acid daily, beginning before pregnancy. Folic acid is a B vitamin found naturally in leafy green vegetables, beans, citrus fruits, and juices. Since January 1998, the Food and Drug Administration has required that all foods containing enriched flour, such as breads, pasta, and breakfast cereal, be fortified with folic acid. In addition to consuming a diet high in folate-rich foods, a daily multivitamin is one of the most reliable sources of folic acid. A majority of women are not aware of this prevention opportunity, nor are they consuming the recommended daily amount. A national folic campaign is needed to urge women to take this simple step to prevent neural tube defects.

This provision would establish a national folic acid education program to prevent birth defects. CDC, in partnership with the States and local, public, and private entities, is authorized to launch an education and public awareness campaign; conduct research to identify effective strategies for increasing folic acid consumption by women of reproductive capacity; and evaluate the effectiveness of these strategies.

TITLE III—PEDIATRIC PUBLIC HEALTH PROMOTION

Subtitle A—Asthma

Asthma is the most common chronic disease of childhood. It affects nearly five million children under the age of 18 in the United States, and the incidence is dramatically increasing. Several studies suggest that between 1980 and 1994, asthma increased 160% among children under age 4, and 74% among children aged 5–14. According to the National Center for Health Statistics, children under 18 years of age miss nearly 72 out of every 1,000 school days due to asthma. This is more than three times the number of missed school days than their unaffected peers accounting for almost 10 million missed days each year.

This provision would authorize the Secretary to award grants to provide comprehensive asthma services to children, equip mobile care clinics, conduct patient and family education on asthma management, and identify children eligible for Medicaid, the State Children's Health Insurance Program, and other children's health programs. This provision amends the Preventive Health and Health Services Block Grant program to provide for the establishment, operation, and coordination of effective and cost-

efficient systems to reduce the prevalence of asthma and asthma-related illnesses among urban populations, especially children, by reducing the level of exposure to cockroach allergen through the use of integrated pest management. This provision also requires HHS to establish a coordinating committee to identify all Federal programs that carry out asthma-related activities; develop, in consultation with appropriate Federal agencies, professional and voluntary health organizations, a Federal plan for responding to asthma; and submit recommendations to Congress within 12 months after enactment regarding ways to strengthen and improve the coordination of asthma-related Federal activities.

Subtitle B—Childhood Obesity Prevention

Obesity has increased by more than 50 percent among adults and 100 percent among children in just the past 15 years. Approximately 4.7 million children, or 11% of youths ages 6–19 years are seriously overweight. Obesity is associated with many of the leading causes of death and disability, including heart disease, diabetes, certain forms of arthritis, and cancer. Research shows that 60% of overweight 5 to 10 year old children already have at least one risk factor for heart disease (hyperlipidemia, hypertension, or altered insulin levels). Almost 25 percent of young people ages 6–17 are overweight, and the percentage who are seriously overweight has doubled in the last 30 years. Part of the reason for youth inactivity is the reduction of daily participation in high school physical education classes has declined from 42 percent in 1991 to 27 percent in 1997.

This provision would authorize the CDC to administer a competitive grant program to support the development, implementation, and evaluation of state and community-based programs to promote good nutrition and increased physical activity among American children and adolescents. States would be required to develop comprehensive, inter-agency school- and community-based approaches to encourage and promote nutrition and physical activity in local communities. The proposal would allow CDC to provide states with technical support as well as disseminate information about effective prevention strategies and interventions in treating obesity.

The CDC will coordinate and conduct research to improve our understanding of the relationship between physical activity, diet, health, and other factors that contribute to obesity. Research will also focus on developing and evaluating effective strategies for the prevention and treatment of obesity and eating disorders, as well as study the prevalence and cost of childhood obesity and its effects into adulthood.

The CDC in collaboration with State and local health, nutrition, and physical activity experts, will develop a nationwide public education campaign regarding the health risks associated with poor nutrition and physical inactivity, and will promote information on effective ways to incorporate good eating habits and regular physical activity into daily living.

The CDC, in collaboration with HRSA, will develop and carry out a program to train health professionals in effective strategies to better identify, assess, and counsel (or refer) patients with obesity, an eating disorder, or who are at risk of becoming obese or developing an eating disorder. They will also develop and carry out a program to educate and train educators and child care professionals in effective strategies to teach children and their families about ways to improve dietary habits and levels of physical activity.

Subtitle C—Childhood Lead Prevention

At high levels, lead can cause a variety of debilitating health problems, including seizure, coma, and even death. At lower levels, lead can contribute to learning disabilities, loss of intelligence, hyperactivity, and behavioral problems. Screening is a critical element in eliminating childhood lead poisoning because in most cases there are no distinctive or obvious symptoms. Children with elevated blood lead levels are seven times more likely to drop out of high school and six times more likely to have reading disabilities. It costs an average of $10,000 more a year to educate a lead-poisoned child.

This provision requires HRSA to report annually to the Congress on the percentage of children in the Health Centers program who are screened for lead poisoning. Requires HRSA to work with the CDC and HCFA to conduct physician education and training programs on current lead screening policies along with the scientific, medical, and public health basis for such policies.

This provision requires CDC to issue recommendations and establish requirements for its grantees to ensure uniform and complete reporting of blood lead levels from laboratories to State and local health departments and to improve data linkages between health departments, CDC, WIC, Early Head Start, and other federally funded means-tested public benefit programs.

This provision authorizes new funding through the Maternal and Child Health Block Grant to states with a demonstrated need (based on local surveillance data) to conduct outreach and education for families at risk of lead poisoning, provide individual family education designed to reduce exposures to children with elevated blood lead levels, implement community environmental interventions, and ensure continuous quality measurement and improvement plans for communities committed to comprehensive lead poisoning prevention.

Subtitle D—Oral Health

In May 2000, the Surgeon General of the United States published the landmark report, Oral Health in America: A Report of the Surgeon General. The report focuses on the fact that oral health is inseparable from overall health. However, tooth decay is the most prevalent preventable chronic disease of childhood and only the common cold, the flu and onitis media occur more often among young children. And while there have been great improvements in oral health for a majority of the population, there are disparities that primarily affect poor children and those who live in underserved areas of our country, with 80 percent of all dental cavities found in 20 percent of the children. ''The devastating consequences of untreated disease can affect children's health and well being, causing pain and suffering, time lost from school, loss of permanent teeth, self-consciousness and loss of self-esteem, and even more complications in children with coexisting medical conditions.'' The United States must improve and enhance the training of dental health professionals to meet the increasing need for dental services for children .

This provision would require the Secretary of HHS to support community-based research and training to improve the understanding of etiology, pathogenesis, diagnoses, prevention and treatment of pediatric oral, dental and craniofacial diseases and conditions. The Secretary of HHS is authorized to provide grants to States to increase community water fluoridation and to provide school-based dental sealant services to children in low income areas.

TITLE VI—PEDIATRIC RESEARCH

Subtitle A—Pediatric Research Initiative

The rapidly expanding knowledge base in genetics and biomedicine affords an unparalleled opportunity to understand gene-environment interactions and to apply this knowledge to the benefit of children and society. Findings in pediatric research not only promote and maintain health throughout a child's lifespan, but also contribute significantly to new insights and discoveries that will aid in the prevention and treatment of illnesses and conditions among adults. A growing body of evidence shows that risk factors for diseases such as coronary artery disease and stroke begin in childhood and persist through adulthood.

This provision would establish a Pediatric Research Initiative within the National Institutes of Health (NIH) to enhance collaborative efforts, provide increased support for pediatric biomedical research, and ensure that expanding opportunities for advancement in scientific investigations and care for children are realized.

The Secretary of Health and Human Services (HHS) will make available enhanced support for activities relating to the training and career development of pediatric researchers, including general authority for loan repayment of a portion of education loans.

Subtitle B—Autism

Autism and autism spectrum disorders are biologically-based neurodevelopment diseases that cause severe impairments in language and communication. These disorders often manifest in young children sometime during the first two years of life. Estimates indicate that 1 in 500 children born today will be diagnosed with an autism spectrum disorder and that 400,000 Americans have autism or an autism spectrum disorder.

Under this provision, the Director of NIH shall expand, intensify, and coordinate the activities of the NIH with respect to research on autism. The Director of NIH will carry out through NIMH and other agencies that may be appropriate, and establish not less than five Centers of Excellence on autism research. Each center will conduct basic and clinical research into the cause, diagnosis, early detection, prevention, control and treatment of autism, including research in the fields of developmental neurobiology, genetics and psychopharmacology. The Director shall provide for the coordination of information among centers. A center may provide individuals referrals for health and other services and patient care services as required for research. The Director shall provide for a program under which samples of tissues and genetic materials that are of use in research on autism are made available for this research.

The proposal also establishes through the CDC, at least three regional centers of excellence in autism and pervasive developmental disabilities epidemiology to collect and analyze information on the number, incidence, and causes of autism and related developmental disabilities would be established. The Secretary shall establish a program to provide information on autism to health professionals and the general public, and establish an Autism Coordinating Committee to coordinate all efforts within HHS on autism.

Subtitle B—Child Development Study

Findings in pediatric research not only promote and maintain health throughout a child's lifespan, but also contribute significantly to new insights and discoveries that will aid in the prevention and treatment of illnesses and conditions among adults. A growing body of evidence shows that risk factors for diseases such as coronary artery disease and stroke begin in childhood and persist through adulthood. Children are more vulnerable to physical, chemical, biological, safety, and psychosocial exposures than adults. Evidence-based policies and effective

prevention and health promotion strategies to achieve a healthy and safe environment for children and families, are best derived from a federal multi-agency longitudinal study.

Authorizes NICHD to convene and direct a consortium of federal agencies, including CDC and EPA, to plan, develop and implement a prospective cohort study to evaluate the effects of both chronic and intermittent exposures on human development, and to investigate basic mechanisms of developmental disorders and environmental factors, both risk and protective, that influence growth and development processes. The study will incorporate behavioral, emotional, educational, and contextual consequences to enable a complete assessment of the physical, chemical, biological and psychosocial environmental influences on children's well-being.

The study shall include diverse populations, before birth, to gather data on environmental influences and outcomes until at least age 21, and shall consider health disparities.

Subtitle D—Research on Rare Diseases

This Provision would require the NIH Director to report to Congress within 180 days of enactment regarding activities conducted and supported by the NIH during Fiscal Year 2000 with respect to rare diseases in children and the activities that are planned to be conducted and supported by the NIH with respect to such diseases during the Fiscal Years 2001 through 2005.

Subtitle E—GME in Children's Hospitals

The health of the nation's children depends upon a steady supply of well-trained pediatricians and pediatric specialists. Independent children's hospitals train about half of all pediatric specialists, and 30 percent of pediatricians. Graduate medical education (GME) activities have historically been supported by Medicare, but, because these hospitals serve very few Medicare patients, they receive very little financial support for this important and costly activity. Children's hospitals are an important resource for all children. The training, pediatric research, and primary and specialty care services that occur in these facilities should be preserved and strengthened. Unfortunately, however, many of these hospitals are struggling to maintain their missions. Last year, a new program was authorized to provide discretionary support for pediatric GME activities in free-standing children's hospitals. This provision extends the authorization to 2005.

Mr. JEFFORDS. Mr. President, it gives me great pleasure to join my colleagues today in introducing the Children's Health Act of 2000. This bill authorizes a variety of programs and initiatives that promise to significantly improve the health of children in this nation. I want to commend Senators FRIST, KENNEDY, DODD, GREGG, DEWINE, REED, BOND, GORTON, ABRAHAM, and DURBIN for their work and commitment to protecting and improving the health of our children.

This bill takes a multifaceted approach in addressing the most pressing healthcare problems facing our children today, such as brain injury, birth defects, asthma, and obesity. The bill authorizes prevention programs, educational programs, clinical research, and direct clinical care services. It also enhances the training and knowledge base of pediatric healthcare researchers through training and loan repayment programs. In the face of so many dangerous diseases and conditions, the holistic approach taken by this bill offers the best hope for protecting and improving our children's health.

This bill provides funding for critical research on children's heath. The Pediatric Research Initiative, based in the National Institutes of Health, will lay the foundation for comprehensive, cross cutting pediatric biomedical research. Such a center has the potential to yield valuable new information on child growth and development.

The Child Development Study, a long term study of environmental influences on children's health, will also yield important insights into the environmental factors that influence the growth and development of our children. This understanding will play a critical role in shaping future policy and programs for children's health. This research, in addition to other research opportunities provided in this bill promises to significantly improve our ability to protect the health of our children.

In addition to research, this bill provides resources for care and prevention programs. For example, this bill authorizes aggressive programs to prevent and treat one of the most challenging childhood health problems, traumatic brain injury. The Centers for Disease Control and Prevention is directed to conduct research on prevention and to implement public education and information programs. The Health Research and Services Administration is authorized to fund community support services to develop support or enhance care systems for individuals with brain injuries. These programs, coupled with research at NIH, address both the causes and the consequences of traumatic brain injury.

This bill authorizes the creation of a National Center for Birth Defects and Developmental Disabilities to collect, analyze, and distribute data on birth defects. This provision will allow for important data to be developed to guide the development of programs and policies to assist children and families coping with disabilities. Having worked for many years to improve the quality of life of people living with disabilities, I strongly support this effort to address the challenges of disabilities at the earliest age possible. This center will help to coordinate and focus our approach, and serve as a clearinghouse for information that will improve both healthcare and quality of life for children with disabilities.

By targeting asthma, the most common chronic disease of childhood, this bill will make a difference in the lives of thousands of children and young people who suffer with this disease across the nation. Asthma jumped by 75 percent in the general population between 1980 and 1994. Among children under four there was a rise of 160 percent. It is estimated that this condition debilitates about 33,000 Vermonters (22,000 adults and 11,000 children). Grant programs authorized under this bill will fund comprehensive asthma services, mobile health care clinics, and patient and family education to reduce the impact of this dangerous disease. As this disease continues to strike more and more of our youth, it is critical that programs to reduce asthma have priority.

Oral health is also improved under this legislation, which targets the disparities in access to dental care and preventive therapies among poor children. In addition to direct care services, this provision enhances community based research and training to improve our knowledge of effective clinical and preventive measures. With 20 percent of children experiencing 80 percent of the dental cavities, it is time we focus on this neglected population and make a difference in their health.

An investment in the health of the nation's children will undoubtedly have long term rewards, as we move our understanding of and ability to treat childhood diseases far beyond current capabilities. Clearly, the time has come to comprehensively and aggressively tackle the primary causes of poor health for our children. I strongly support this legislation. The health of the nation rests on the health of our children, and we must do all we can to prevent and treat diseases that strike at the most vulnerable members of society.

Mr. KENNEDY. Mr. President, it is a privilege to join Senator FRIST and our other colleagues in introducing the Children's Public Health Act of 2000. This bipartisan legislation will help millions of children in the years ahead. It takes needed action to improve children's health by expanding pediatric research and calling for specific steps to deal with a wide range of childhood illness, disorders, and injuries. Coordinated action in these areas can lead to significant benefits for all children.

Senator FRIST and I have worked closely with many of our Democratic and Republican colleagues on this legislation. We have talked with experts and advocates in the children's health community. We believe this legislation will lead to significant progress in addressing some of today's most pressing pediatric public health problems.

The legislation includes a variety of new and reauthorized children's health provisions that are organized under four broad categories—injury prevention, maternal and infant health promotion, public health promotion, and research.

Traumatic brain injury is the leading cause of death and disability in young Americans. The Centers for Disease Control and Prevention has estimated that 5.3 million Americans are living with long-term, severe disability as a result of brain injuries, and each year 50,000 people die as a result of such injuries. The Children's Public Health Act revises and extends the authorization for the important programs enacted in 1996 to deal with these injuries. This reauthorization will assure

continued progress toward our understanding, treating and preventing them.

Improving and protecting the safety of child care environments should also be a high priority for Congress. This legislation creates a new program to improve the safety of children in child care settings, and to encourage child care providers to take steps to prevent illness and injuries and protect the health of the children they serve.

In addition, this legislation includes programs to improve the health of pregnant women and prenatal outcomes, including prevention of birth defects and low birth weight. It establishes a new Center for Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention in order to focus the nation's activities more effectively in these important areas. The new center will be especially helpful for children and families affected by these conditions.

The bill also takes a number of steps to address other prevalent childhood conditions. Asthma is the most common chronic childhood illness, affecting more than seven percent of all American children. The death rate for children with asthma increased by 78 percent between 1980 and 1993, and asthma-related costs total nearly $2 billion annually in direct health care for children. The nation is handicapped by a lack of basic information on where and how asthma strikes, what triggers it, and how effectively our current health care system is responding to those who suffer from this chronic disease. Our bill will provide greater asthma services to children, including mobile clinics, and patent and family education, and it will help to reduce allergens in housing and public facilities.

Poor nutrition and lack of physical activity are also hurting many American children and contributing to lifelong health problems. The nation spends $39 billion a year—equal to six percent of overall U.S. health care expenditures—on direct health care related to obesity. Twenty percent of American children—one in five—are overweight. Unhealthy eating habits and physical inactivity in childhood can lead to heart disease, cancer and other serious illnesses decades later. Children and adolescents who suffer from eating disorders, such as anorexia nervosa and bulimia, can have wide-ranging physical and mental health impairments. Our legislation establishes new grant programs to reduce childhood obesity and earing disorders, promote better nutritional habits among children, and encourage an appropriate level of physical activity for children and adolescents.

Last May, the Surgeon General published a landmark report on oral health in America, emphasizing the need to consider oral health as an essential part of total health. There is no question that oral and dental health care should be included in our primary care. Tooth decay is the most common childhood infectious disease, and it can lead to devastating consequences, including problems with eating, learning and speech. Twenty-five percent of children in the United States suffer 80 percent of the tooth decay, with significant racial and age disparities. The number of dentists in the country has been declining since 1990, and is projected to continue to decline through the year 2020.

According to a 1995 report by the Inspector General, only one in five Medicaid-eligible children receive dental services annually, and the shortage of dentists exacerbates the problem of unmet needs. Yet tooth decay is largely preventable. More effective efforts to educate parents and children about the causes of tooth decay, and initiatives to prevent and treat it can lead to lasting public health improvements. Our legislation includes a variety of approaches to deal with this silent epidemic.

Research has long shown that childhood lead poisoning can have devastating effects on children, causing reduced IQ and attention span, stunted growth, behavior problems, and reading and learning disabilities. Yet too children remain unscreened and untreated, and adequate services often are not available for children with elevated levels of lead in their blood. There is no excuse for not taking greater steps to eliminate childhood lead poisoning. Our bill includes screening for early detection and treatment, professional education and training programs, and outreach and education activities for at-risk children.

Pediatic research discoveries promote and maintain health throughout a child's life span, and also contribute significantly to new insights that aid in the prevention and treatment of illnesses and conditions among adults. A growing body of evidence shows that risk factors for conditions such as coronary artery disease and stroke begin in childhood and persist through adulthood. Congress has a strong history of promoting basis and clinical research, and the steps taken in this legislation continue that priority.

The legislation establishes a pediatric research initiative, authorized at $50 million annually, that will increase support for pediatric biomedical research at the National Institutes of Health, including an increase in collaborative efforts among multidisciplinary fields in areas that are promising for children. The legislation also requires coordination with the Food and Drug Administration to increase the number of pediatric clinical trails, and to provide greater information on safer and more effective use of prescription drugs in children.

Children have unique health care needs. They are not simply small adults. Nothing is more important to the future health of America's children than maintaining a steady supply of pediatricians, pediatric specialists and pediatric-focused scientists.

Our legislation takes two important steps to improve the growth and development of a pediatric-focused medical community. First, it enhances support by the National Institute for Child Health and Human Development expressly for training and career development activities of pediatric researchers, and it establishes a loan repayment program for pediatricians who conduct research.

Second, it extends the authorization of a new program that supports graduate medical education activities at independent children's hospitals. These hospitals train half of all pediatric specialists, and 30 percent of all pediatricians. However, because GME activities have historically been supported by Medicare and because these hospitals serve very few Medicare patients, they receive very little financial support for this important and costly activity. As a result, children's hospitals are struggling to maintain the important training, pediatric research, and primary and specialty care services that they provide. Children's hospitals should be treated like all other teaching hospitals when it comes to support for their GME activities. I have sponsored another legislative proposal to guarantee full funding each year, without being subject to the appropriations process. That proposal is awaiting consideration in the Finance Committee. Until it is enacted, we owe it to America's children to invest in their future health care by improving our support for pediatric GME activities.

The bill also authorizes a new study to monitor and evaluate development of children through adulthood. The kind of information that will be obtained by this study is long-overdue. Children are more vulnerable to physical, chemical, biological, and other risks than adults, and we must make a major commitment to learning more about the influences and effects of the environment.

Finally, this legislation also includes a program to address the unique needs of children with autism and related disorders. I look forward to working with Chairman FRIST, members of the Committee and others to assure that the needs of children with Fragile X are met in the final legislation.

This legislation deserves to be a major public health priority for the nation. Congress should send the President a strong bill on these issues before the end of this year.

Mr. DEWINE. Mr. President, I rise today as a co-author of the ''Children's Public Health Act of 2000.'' The sad fact is that far too many children never realize success as adults or even reach adulthood because of debilitating or life-threatening disease. That is why we must build a health care system that is responsive to the unique needs of children. The ''Children's Public Health Act of 2000'' is a big step in the right direction, and I commend my colleagues, Senators FRIST, JEFFORDS, and KENNEDY for their efforts to construct a bill that can really make a positive difference in the health and the lives of children.

Mr. President, I am especially pleased that the ''Children's Public Health Act'' contains several important initiatives that my colleagues and I had already introduced as separate bills. One such initiative—the Pediatric Research Initiative—would help ensure that more of the increased research funding at the National Institutes of Health (NIH) is invested specifically in children's health research.

While children represent close to 30 percent of the population of this country, NIH devotes only about 12 percent of its budget to children, and, in recent years, that proportion has been declining even further. We must reverse this disturbing trend. It simply makes no sense to conduct health research for adults and hope that those findings also will apply to children. A ''one-size-fits-all'' research approach just doesn't work. The fact is that children have medical conditions and health care needs that differ significantly from adults. Children's health deserves more attention from the research community. That's why the Pediatric Research Initiative is such an important part of the ''Children's Public Health Act.'' It would provide the federal support for pediatric research that is so vital to ensuring that children receive the appropriate and best health care possible.

The Pediatric Research Initiative would authorize $50 million annually for the next five years for the Office of the Director of NIH to conduct, coordinate, support, develop, and recognize pediatric research. By doing so, we will be able to ensure that researchers target and study child-specific diseases. With more than 20 Institutes and Centers and Offices within NIH that conduct, support, or develop pediatric research in some way, this investment would promote greater coordination and focus in children's health research and should encourage new initiatives and areas of research.

The ''Children's Public Health Act'' also would authorize funding through the National Institutes of Child Health and Human Development (NICHD)—for pediatric research training grants to support training for additional pediatric research scientists and would provide funding for loan forgiveness programs. Trained researchers are essential if we are to make significant advances in the study of pediatric health care, especially in light of the new and improved Food and Drug Administration (FDA) policies that encourage the testing of medications for use by children.

Additionally, the ''Children's Public Health Act'' includes the ''Children's Asthma Relief Act,'' which Senator DURBIN and I introduced last year. The sad reality for children is that asthma is becoming a far too common and chronic childhood illness. From 1979 to 1992, the hospitalization rates among children due to asthma increased 74 percent. Today, estimates show that more than seven percent of children now suffer from asthma. Nationwide, the most substantial prevalence rate increase for asthma occurred among children aged four and younger. Those four and younger also were hospitalized at the highest rate among all individuals with asthma.

According to 1998 data from the Centers for Disease Control (CDC), my home state of Ohio ranks about 17th in the estimated prevalence rates for asthma. Based on a 1994 CDC National Health Interview Survey, an estimated 197,226 children under 18 years of age in Ohio suffer from asthma. This is a serious health concern among children—and we must address it.

The ''Children's Public Health Act'' would help ensure that children with asthma receive the care they need to live healthy lives. The bill would authorize $50 million annually for five years for the Secretary of Health and Human Services (HHS) to award grants to eligible entities to develop and expand projects that would provide asthma services to children. These grants also may be used to equip mobile health care clinics that provide asthma diagnosis and asthma-related health care services; educate families on asthma management; and identify and enroll uninsured children who are eligible for, but are not receiving health coverage under Medicaid or the State Children's Health Insurance Program (SCHIP). The ability to identify and enroll children in these programs will ensure that children with asthma receive the care they need.

Since research shows that children living in urban areas suffer from asthma at such alarming rates and that allergens, such as cockroach waste, contribute to the onset of asthma, this bill also adds urban cockroach management to the current preventive health services block grant which currently can be used for rodent control.

To better coordinate federal activities related to asthma, the Secretary of HHS would be required to identify all federal programs that carry out asthma research and develop a federal plan for responding to asthma. To better monitor the prevalence of pediatric asthma and to determine which areas have the greatest incidences of children with asthma, this bill would require the CDC to conduct local asthma surveillance activities to collect data on the prevalence and severity of asthma and to publish data annually on the prevalence rates of asthma among children and on the childhood mortality rate. This surveillance data will help us better detect asthmatic conditions, so that we can treat more children and ensure that we are targeting our resources in an effective and efficient way to reverse the disturbing trend in the hospitalization and death rates of asthmatic children.

Finally, Mr. President, the bill we are introducing today includes language that I strongly support to re-authorize funding for children's hospitals' Graduate Medical Education (GME) programs for four additional years. Last year, as part of the ''Health Care Research and Quality Act,'' which was signed into law, we authorized funding for two years for children's hospitals' GME programs. The teaching mission of these hospitals is essential. Children's hospitals comprise less than one percent of all hospitals, yet they train five percent of all physicians, nearly 30 percent of all pediatricians, and almost 50 percent of all pediatric specialists. By providing our nation with highly qualified pediatricians, children's hospitals can offer children the best possible care and offer parents peace of mind. They serve as the health care safety net for low-income children in their respective communities and are often the sole regional providers of many critical pediatric services. These institutions also serve as centers of excellence for very sick children across the nation. Federal funding for GME in children's hospitals is a sound investment in children's health and provides stability for the future of the pediatric workforce.

Mr. President, as the father of eight children and the grandfather of five, I firmly believe that we must move forward to protect the interests—and especially the health—of all children. The ''Children's Public Health Act of 2000'' makes crucial investments in our country's future—investments that will yield great returns. If we focus on improving health care for all children today, we will have a generation of healthy adults tomorrow.

I urge my colleagues to support this vital children's health care bill.

By Mr. HATCH (for himself, Mr. KENNEDY, Mr. HUTCHINSON, Mr. DASCHLE, Mr. BENNETT, Mr. LIEBERMAN, and Mr. SCHUMER):

S. 2869. A bill to protect religious liberty, and for other purposes; read the first time.

RELIGIOUS LAND USE AND INSTITUTIONALIZED PERSONS ACT OF 2000

Mr. HATCH. Mr. President, I rise today to introduce a narrowly focused bill that protects religious liberty from unnecessary governmental interference. It will provide protection for houses of worship and other religious assemblies from restrictive land use regulation that often prevents the practice of faith. This legislation also allows institutionalized persons to exercise their religion to the extent that it does not undermine the security, discipline, and order of their institutions.

Seven years ago, recognizing the need to strengthen the fundamental right of religious liberty, Congress overwhelmingly passed the Religious Freedom Restoration Act (RFRA). Unfortunately, in 1997, in the case of City of Boerne v. Flores, the Supreme Court held that Congress lacked the authority to enact RFRA as applied to state and local governments. In an attempt to respond to the Boerne decision, I introduced S. 2081 earlier this year. Legislation similar to S. 2081 passed the

House of Representatives. Yet, concerns were raised by some regarding the scope of S. 2081, and I undertook an effort to seek out a consensus approach. The legislation I am introducing today, which maintains certain provisions of S. 2081, is a tailored version which represents the product of our efforts.

The Religious Land Use and Institutionalized Persons Act of 2000 provides limited federal remedies for violations of religious liberty in: (1) the land use regulation of churches and synagogues; and (2) prisons and mental hospitals.

LAND USE REGULATION

At the core of religious freedom is the ability for assemblies to gather and worship together. Finding a location to do so, however, can be quite difficult when faced with pervasive land use regulations. As was seen during congressional hearings in both the House and Senate, land use regulations, either by design or neutral application, often prevent religious assemblies and institutions from obtaining access to a place of worship. Under current law, an assembly whose religious practice is burdened by an otherwise ''generally applicable'' and ''neutral'' law can obtain relief only by carrying the heavy burden of proving that there is an unconstitutional motivation behind a law, and thus, that it is not truly neutral or generally applicable. Such a standard places a seemingly insurmountable barrier between the religious assemblies of our country and their right to worship freely.

An example of this was seen recently when a city refused to allow the LDS Church to construct a temple simply because it was not in the ''aesthetic'' interests of the community as set forth in a ''generally applicable'' statute. Another example includes an effort to suspend the operation of a religious mission for the homeless operated by the late Mother Teresa's order because it was located on the second floor of a building without an elevator.

The land use section of the bill prohibits discrimination against religious assemblies and institutions, and prohibits the total exclusion of religious assemblies from a jurisdiction. The section also prohibits unreasonable limits on religious assemblies and institutions and requires that land use regulations that substantially burden the exercise of religion be justified by a compelling governmental interest.

It is important to note that this legislation does not provide a religious assembly with immunity from zoning regulation. If the religious claimant cannot demonstrate that the regulation places a substantial burden on sincere religious exercise, then the claim fails without further consideration. If the claimant is successful in demonstrating a substantial burden, the government will still prevail if it can show that the burden is an unavoidable result of its pursuit of a compelling governmental objective.

INSTITUTIONALIZED PERSONS

Our bill also provides that substantial burdens on the religious exercise of institutionalized persons must be justified by a compelling interest. Congressional witnesses have testified that institutionalized persons have been prevented from practicing their faith. For example, some Jewish prisoners have been denied matzo, the unleavened bread Jews are required to consume during Passover, even though Jewish organizations have offered to provide it to inmates at no cost to the government. While this legislation seeks to improve the ability of institutionalized persons to practice their religion, it remains under the complete application of the Prison Litigation Reform Act of 1995.

Both sections are based firmly on constitutional principles that grant Congress its authority. Thus, today's legislation should withstand the scrutiny that has thwarted our efforts in the past.

As we begin in this effort, it is worth pondering just why America is, worldwide, the most successful multi-faith country in all recorded history. The answer is to be found, I submit, in both components of the phase ''religious liberty.'' Surely, it is because of our Constitution's zealous protection of liberty that so many religions have flourished and so many faiths have worshiped on our soil.

Our country has achieved its greatness because, with its respectful distance from our private lives, our government has allowed all its citizens their own forms of ''internal governance,'' that is, those religious and moral tenets that make a free society possible. Our country has allowed people to answer for themselves, and without interference, those questions that are most fundamental to humankind. And it is in the way that religion informs our answers to these questions, that we not only survive, but thrive as human beings.

While this bill provides much needed preservation of our religious liberty, I personally would have preferred a broader approach. I recognize, however, in this shortened legislative year, the long list of items before the congressional leadership that require their attention. In order to ensure enactment of a measure this year, I think all advocates of a broader approach took a prudent step in embracing a more targeted, consensus bill.

With the help of Senator KENNEDY, Congressman CANADY, and others, I hope this legislation will move swiftly through the Congress. We look forward to welcoming others to our modest, yet important, effort to enact this legislation.

Mr. KENNEDY. Religious freedom is a bedrock principle in our nation. The bill we are introducing today reflects our commitment to protect religious freedom and our belief that Congress still has the power to enact legislation to enhance that freedom, even after the Supreme Court's decision in 1997 to strike down the broader Religious Freedom Restoration Act that 97 Senators joined in passing in 1993.

In striking down the Religious Freedom Restoration Act on constitutional grounds, the Court clearly made the task of passing effective legislation to protect religious liberties more difficult. But too often in our society today, thoughtless and insensitive actions by governments at every level interferes with individual religious freedoms, even though no valid public purpose is served by the governmental action.

Our goal in proposing this legislation is to reach a reasonable and constitutionally sound balance between respecting the compelling interests of government and protecting the ability of people freely to exercise their religion. We believe that the legislation being introduced today accomplishes this goal in two areas where infringement of this right has frequently occurred—the application of land use laws, and treatment of persons who are institutionalized. In both of these areas, our bill will protect the Constitutional right to worship, free from unnecessary government interference.

After numerous Congressional hearings on religious liberties, the evidence is clear that local land use laws often have the discriminatory effect of burdening the free exercise of religion. It is also clear that institutionalized persons are often unreasonably denied the opportunity to practice their religion, even when their observance would not undermine discipline, order, or safety in the facilities.

Relying upon the findings from Congressional hearings, we have developed a bill—based upon well-established constitutional authority—that will protect the free exercise of religion in these two important areas. Our bill has the support of the Free Exercise Coalition, which represents over 50 diverse and respected groups, including the Family Research Council, Christian Legal Society, American Civil Liberties Union, and People for the American Way. The bill also has the endorsement of the Leadership Conference for Civil Rights.

The broad support that this bill enjoys among religious groups and the civil rights community is the result of many months of difficult, but important negotiations. We carefully considered ways to strengthen religious liberties in other ways in the wake of the Supreme Court's decision. We were mindful of not undermining existing laws intended to protect other important civil rights and civil liberties. It would have been counterproductive if this effort to protect religious liberties led to confrontation and conflict between the civil rights community and the religious community, or to a further court decision striking down the new law. We believe that our bill succeeds in avoiding these difficulties by addressing the most obvious threats to

religious liberty and by leaving open the question of what future Congressional action, if any, will be needed to protect religious freedom in America.

The land use provision covers regulations defined as ''zoning and landmarking'' laws. Under this provision, if a zoning or landmarking law substantially burdens a person's free exercise of religion, the government involved must demonstrate that the particular law is the least restrictive means of furthering a compelling governmental interest. This provision is based upon the constitutional authority of Congress under Section 5 of the 14th Amendment, as well as the Commerce and Spending powers of Congress. The institutionalized persons section applies the strict scrutiny standard to cases in which the free exercise rights of such persons are substantially burdened. This provision is based upon Congress's constitutional authority under the Spending and Commerce powers.

Applying a strict scrutiny standard to prison regulations would not lead, as some have suggested, to a flood of frivolous lawsuits by prisoners, and it will not undermine safety, order, or discipline in correctional facilities. Arguments opposing this provision have been made in the past, but they were based on speculation. Now, the arguments can be proven demonstrably false by the facts.

Since the Religious Freedom Restoration Act was enacted in 1993, strict scrutiny has been the applicable standard in religious liberties case brought by inmates in federal prisons. Yet, according to the Department of Justice, among the 96 federally run facilities, housing over 140,000 inmates, less than 75 cases have ever been brought under the Act—most of which have never gone to trial. On average, over seven years, that's less than 1 case in each federal facility. It's hardly a flood of litigation or a reason to deny this protection to prisoners.

Following the enactment of the 1993 Act, Congress also passed the Prison Litigation Reform Act, which includes a number of procedural rules to limit frivolous prisoner litigation. Those procedural rules will apply in cases brought under the bill we are introducing today. Based upon these protections and the data on prison litigation, it is clear that this provision in our bill will not lead to a flood of frivolous lawsuits or threaten the safety, order, or discipline in correctional facilities. Sincere faith and worship can be an indispensable part of rehabilitation, and these protections should be an important part of that process.

In sum, our bill is an important step forward in protecting religious liberty in America. It reflects the Senate's long tradition of bipartisan support for the Constitution and the nation's fundamental freedoms, and I urge the Senate to approve it.

EXAMPLES OF LAND USE RESTRICTIONS ON RELIGIOUS LIBERTY

In February 2000, a city official in Portland, Oregon ordered a local United Methodist Church to limit attendance at its services to 70 worshipers and shut down a meals program for the homeless and the working poor that the church had been operating for sixteen years. The church can hold up to 500 persons. The land use official announced that her job was ''quasi-judicial,'' and that ''she was not required to explain decisions.'' After a public outcry, the Portland City Council unanimously rejected the attendance cap and voted to allow church programs to continue, contingent on an agreement being reached among neighbors, neighborhood businesses and the city about the management of the church programs. (''Church ordered to limit attendance,'' Washington Times, February 18, 2000: ''Church wins on attendance,'' The Oregonian, March 2, 2000).

Officials in Arapahoe County, Colorado imposed numerical limits on the number of students who could enroll in religious schools and on the size of congregations of various churches, as a way of limiting their growth. These limits directly conflicted with the mission of evangelical churches, whose fundamental goal is to attract new believers.

In Douglas County, Colorado, administrative officials proposed limiting the operational hours of a church in much the same way as they limit commercial facilities. As Mark Chopko noted in his Congressional testimony, limiting a church's operational hours means that a church may not lawfully engage in certain acts of service and devotion or overnight spiritual retreats. (Testimony of Mark Chopko before the House Subcommittee on the Constitution, March 26, 1998).

Congregation Etz Chaim, an Orthodox Jewish congregation in Los Angeles, was meeting in a rented house, or ''shul'', in Hancock Park, a residential zone. The rabbi of the congregation, Chaim Baruch Rubin, testified that ten to fifteen men would typically visit the house for daily meetings, and forty or fifty people (many elderly and disabled) would attend on the Sabbath or holidays to engage in quiet prayer and study. Orthodox Jews must walk to services on the Sabbath and on most holidays, because their religion does not permit them to use mechanical modes of transportation on those days. When neighbors complained about the effect on property values, the congregation requested a special use permit from the City Council to remain in the residential zone. The Council unanimously rejected the request, putting the neighborhood effectively off-limits for Orthodox Jews. The same Council, however, allowed other places of assembly in Hancock Park, including schools, book clubs, recreational uses and embassy parties. Rabbi Rubin testified that 84,000 cars traveled through this part of the neighborhood daily, and yet somehow the Council deemed a prayer meeting of a few who traveled by foot as harmful to the neighborhood. Rabbi Rubin concluded his testimony by stating, what do I tell my congregants—what do I tell an 84 year old survivor of Auschwitz, a man who used to risk his life in the concentration camp whenever possible to gather together to pray? (Testimony of Rabbi Chaim Baruch Rubin before the House Subcommittee on the Constitution, February 26, 1998).

In the process of creating a new zoning plan covering development in the city, the City of Forest Hills, Tennessee set up an ''educational and religious zone'' called an ''ER'' for schools and churches, but limited that designation to schools and churches that already existed within the city. No other land was zoned ''ER'' under the plan, so no other property was available for the construction of a new religious building. The City also established strict requirements for changing any zone. The Church of Jesus Christ of Latter-day Saints determined a need for a temple in Forest Hills, and sought a zone change for property that it owned within city limits. Forest Hills rejected the church's request. The church then bought another piece of property that had previously been home to a church. Churches of other denominations were nearby. Forest Hills nevertheless rejected the church's second request citing concern about traffic, and a court upheld this determination, effectively precluding Mormons from temple worship within city limits. (Testimony of Von G. Keetch before the House Subcommittee on the Constitution, March 26, 1998; Report of the House Judiciary Committee on the Religious Liberty Protection Act of 1999, 106th Congress).

In 1997, the City of Richmond passed an ordinance which required places of worship wishing to feed more than thirty hungry and homeless people to apply for a conditional use permit at a cost of $1,000, plus $100 dollars per acre of affected property. The ordinance regulated only places of worship, not other institutions, and only eating by persons who are hungry and homeless. The ordinance also limited to seven days, and to the period between October 1 and April 1, the times when places of worship may feed the hungry and homeless. The City had complete discretion over the granting of conditional use permits based on its assessment of a number of subjective factors. The Rev. Patrick Wilson of Richmond, Virginia stated in his testimony: ''A $1,000 fee is beyond the means of most churches, which operate with memberships of less than 100 persons and is therefore prohibitive. Imagine that—a statutorily imposed fee for the exercise of a basic and fundamental tenet of the Christian faith! . . . Health and safety issues can be and are addressed in less

odious ways.'' (Testimony of Rev. Patrick J. Wilson III before the House Subcommittee on the Constitution, February 26, 1998; Preliminary and Jurisdictional Statement in Trinity Baptist Church v. City of Richmond, (E.D.Va. filed August 20, 1997.)

Twenty-two of the twenty-nine zoning codes in the northern suburbs of Chicago effectively exclude churches, unless they have a special use permit. Zoning authorities hold almost wholly discretionary power over whether a house of worship may locate in these areas. John Mauck, a Chicago attorney who serves many churches in this area, handled the case of a church, His Word Ministries to All Nations, interested in buying property after it outgrew its space in the basement of a home. When it sought a special use permit in 1992, an alderman delayed the request three times, resulting in months of delay in the purchase of the building. After the third postponement of the hearing, the alderman had the church's property rezoned as a manufacturing district. Because churches cannot locate in a manufacturing district, the church was forced to withdraw its application for special use after paying filing, attorney and appraiser fees. The church spent approximately $5,000 and wasted an entire year seeking the special use permit. (Testimony of John Mauck before the House Subcommittee on the Constitution, March 26, 1998; Affidavit of Virginia Kantor in Civil Liberties for Urban Believers v. City of Chicago (N.D. Ill. 1994); Testimony of Douglas Laycock before the House Subcommittee on the Constitution, July 14, 1998).

In his testimony, Marc Stern stated that orthodox synagogues are often required to have a specific number of parking spaces, based on the number of seats in the sanctuary—even though the sanctuary will be filled with worshipers who do not drive. (Testimony of Marc Stern before the House Subcommittee on the Constitution, March 26, 1998).

Chicago attorney John Mauck testified about several cases of racially motivated opposition to black churches, and about a case in which the mayor told his city manager that they didn't want Hispanics in the town. He also testified about other statements of bigotry. Marc Stern testified about a case in which a small congregation sought permission to convert a private home into a small synagogue. One council member considering the converted use ''warned that if the application was granted, this nearly all white suburb would begin to resemble an adjoining city which was largely minority and full of storefront churches.'' (Testimony of John Mauck before the House Subcommittee on the Constitution, March 26, 1998; Testimony of Douglas Laycock before the House Subcommittee on the Constitution, July 14, 1998; Testimony of Marc Stern before the House Subcommittee on the Constitution, March 26, 1998).

ADDITIONAL COSPONSORS

S. 818

At the request of Mr. DEWINE, the name of the Senator from Vermont (Mr. JEFFORDS) was added as a cosponsor of S. 818, a bill to require the Secretary of Health and Human Services to conduct a study of the mortality and adverse outcome rates of medicare patients related to the provision of anesthesia services.

S. 922

At the request of Mr. ABRAHAM, the name of the Senator from Georgia (Mr. CLELAND) was added as a cosponsor of S. 922, a bill to prohibit the use of the ''Made in the USA'' label on products of the Commonwealth of the Northern Mariana Islands and to deny such products duty-free and quota-free treatment.

S. 1200

At the request of Ms. SNOWE, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 1200, a bill to require equitable coverage of prescription contraceptive drugs and devices, and contraceptive services under health plans.

S. 2023

At the request of Mr. KENNEDY, his name was added as a cosponsor of S. 2023, a bill to provide for the establishment of Individual Development Accounts (IDAs) that will allow individuals and families with limited means an opportunity to accumulate assets, to access education, to own their own homes and businesses, and ultimately to achieve economic self-sufficiency, and for other purposes.

S. 2084

At the request of Mr. LUGAR, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 2084, a bill to amend the Internal Revenue Code of 1986 to increase the amount of the charitable deduction allowable for contributions of food inventory, and for other purposes.

S. 2106

At the request of Mr. ASHCROFT, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 2106, a bill to increase internationally the exchange and availability of information regarding biotechnology and to coordinate a federal strategy in order to advance the benefits of biotechnology, particularly in agriculture.

S. 2217

At the request of Mr. ABRAHAM, the names of the Senator from Hawaii (Mr. AKAKA), the Senator from Missouri (Mr. ASHCROFT), the Senator from Montana (Mr. BAUCUS), the Senator from Kentucky (Mr. BUNNING), the Senator from Louisiana (Mr. BREAUX), the Senator from Nevada (Mr. BRYAN), the Senator from Ohio (Mr. DEWINE), the Senator from Connecticut (Mr. DODD), the Senator from California (Mrs. FEINSTEIN), the Senator from Florida (Mr. GRAHAM), the Senator from Iowa (Mr. GRASSLEY), the Senator from New Hampshire (Mr. GREGG), the Senator from North Carolina (Mr. HELMS), the Senator from South Carolina (Mr. HOLLINGS), the Senator from Oklahoma (Mr. INHOFE), the Senator from Massachusetts (Mr. KENNEDY), the Senator from Kentucky (Mr. MCCONNELL), the Senator from Alaska (Mr. MURKOWSKI), the Senator from Washington (Mrs. MURRAY), the Senator from New Hampshire (Mr. SMITH), the Senator from South Carolina (Mr. THURMOND), and the Senator from Minnesota (Mr. WELLSTONE) were added as cosponsors of S. 2217, a bill to require the Secretary of the Treasury to mint coins in commemoration of the National Museum of the American Indian of the Smithsonian Institution, and for other purposes.

S. 2299

At the request of Mr. L. CHAFEE, the name of the Senator from Indiana (Mr. LUGAR) was added as a cosponsor of S. 2299, a bill to amend title XIX of the Social Security Act to continue State Medicaid disproportionate share hospital (DSH) allotments for fiscal year 2001 at the levels for fiscal year 2000.

S. 2463

At the request of Mr. FEINGOLD, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 2463, a bill to institute a moratorium on the imposition of the death penalty at the Federal and State level until a National Commission on the Death Penalty studies its use and policies ensuring justice, fairness, and due process are implemented.

S. 2504

At the request of Mr. CRAIG, the name of the Senator from Georgia (Mr. COVERDELL) was added as a cosponsor of S. 2504, a bill to amend title VI of the Clean Air Act with respect to the phaseout schedule for methyl bromide.

S. 2615

At the request of Mr. KENNEDY, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 2615, a bill to establish a program to promote child literacy by making books available through early learning and other child care programs, and for other purposes.

S. 2698

At the request of Mr. MOYNIHAN, the name of the Senator from North Dakota (Mr. CONRAD) was added as a cosponsor of S. 2698, a bill to amend the Internal Revenue Code of 1986 to provide an incentive to ensure that all Americans gain timely and equitable access to the Internet over current and future generations of broadband capability.

S. 2700

At the request of Mr. L. CHAFEE, the name of the Senator from Missouri (Mr. ASHCROFT) was added as a cosponsor of S. 2700, a bill to amend the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 to promote the cleanup and reuse of brownfields, to provide financial assistance for brownfields revitalization,